Vendor Claims Testing Script

Vendor Claim Testing will consist of six required phases.

1) The first phase is verification with the vendor that the IBHIS setup is complete and the types of services provided by their vendors are identified.
2) The second phase is identifying Providers for each claiming scenario that must be validated.
3) The third phase is verification of the Original claim scenario for each required service.
4) The fourth phase is verification of Replacement claiming scenarios.
5) The fifth phase is verification of Void claiming scenarios.
6) The sixth phase is verification that the vendor submits an Approved claim for every provider they support.

IBHIS Setup and Testing Verification:

Vendor and testing analyst will confirm the following information:

1) Submitter ID/DUNS Number
2) 835 Defaults – information that will appear on the providers 835s
3) Services that the provider will be claiming for – in addition to MediCal and Indigent (Non-Medi-Cal) outpatient services, does the provider claim for Katie A, Day Treatment (Day Treatment – Full and/or Half Day; Day Rehab – Full and/or Half Day), Community Outreach Services, Inpatient, Residential, PHF services, Life Support, Urgent Care Centers.

Verification of Client, EPIS & Financial Eligibility:

Vendor will create Clients and the EPIS using Web Services for all identified provider services and validate the FE.

1) MediCal Client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
2) Katie A Client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
3) Indigent Client (Non-Medi-Cal): Financial Eligibility set up in Guarantor Order as follows:
    (1) NonMediCalGuarantor with Guarantor Name of LA County
4) Medi-Medi client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
5) OHC-MediCal client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
6) Day Treatment client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
7) Residential client: Residential Episode created at the Residential Program of Service level with Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
8) Inpatient client: Inpatient Episode created at the Inpatient Program of Service level with Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
9) PHF client: PHF Episode created at the PHF Program of Service level with Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
10) Life Support client: Life Support Episode created at the Life Support Program of Service level with Guarantor Order as follows:
    (1) NonMediCalGuarantor with Guarantor Name of LA County

Claiming Cycle 1 Verification:

Following the positive validation of the client's Financial Eligibility, the Vendor will submit claims in the following listed scenarios, and while submitting the files, please adhere to the naming convention of <ProviderInitial>_<DUNSnumber>_837P_Scen_<Scenario Number>_<YYYYMMDD> .txt (e.g. SSG_000000000_837P_Scen1_20140201.txt)

1) MediCal Client - Financial Eligibility for MediCal (10) and LA County (16)
   a) One outpatient service utilizing a service code of the vendor's choice
2) Katie A Client - Financial Eligibility for MediCal (10) and LA County (16). This scenario only applies to Legal Entities who are approved to use the Katie A service codes:
   - Intensive Care Coordination – ICC – T1017:HK
   - Intensive Home Based Services - IHBS – H2015:HK

   a) One outpatient service utilizing a service code of the vendor's choice
      The claim must include the Katie A identifier REF segment (REF*P4*KTA)
3) Indigent Client (Non-Medi-Cal) - Financial Eligibility for LA County (16)
   a) One outpatient service utilizing a service code using P Authorization for Non-MediCal Funding Source
4) Medi-Medi Client
   a) One outpatient service utilizing a service code with partial payment from payer Medicare
5) OHC-Medi-Cal Client
   a) One outpatient service utilizing a service code with partial payment from payer OHC
6) Day Treatment Client - DMH will provide the Member Authorization # and allowable dates of service for claiming as follows:
   a) One Day Treatment or Day Rehab service code using the assigned M Authorization
7) Residential Client
   a) One residential service
8) Inpatient Client
   a) One inpatient service - Inpatient Hospital and/or Admin Hospital Day (mode 5)
9) PHF Client
   a) One PHF service
10) Life Support Client
   a) One Life Support service
11) COS Claim using the default COS client
   a) One COS service

Claiming Cycle 1 verification will be considered complete when the vendor has submitted an Approved claim for each category above; provided that the Provider they support provides these types of services.

Claiming Cycle 2 Verification:

Once the 1st cycle has been validated and communicated to the vendor, the vendor will submit 2 claims to Replace claims that were submitted in the 1st claim cycle. The Vendor will submit claims as follows:

1) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '59'
   Note: the Katie A service codes do not use the '59' modifier.
   Note: the non-Medi-Cal Funding Sources do not use the '59' modifier. Do not replace the Scenario 3 claim using the duplicate modifier '59'
2) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '76'
   Note: the non-Medi-Cal Funding Sources do not use the '76' modifier. Do not replace the Scenario 3 claim using the duplicate modifier '76'

Claiming Cycle 2 verification will be considered complete when the provider has submitted an Approved claim for each category above.

Claiming Cycle 3 Verification:

Once the 2nd cycle of Vendor Claim Readiness has been validated and communicated to the Vendor, the vendor will submit 1 claim to Void a claim that was submitted in the 1st claim cycle. The Vendor will submit the claim as follows:

1) Void an Approved Claim from Claiming Cycle 1

Claiming Cycle 3 verification will be considered complete when the vendor has submitted an Approved claim for each category above.

Provider Claim Verification:

Once the 3rd cycle has been completed and validated the Vendor is required to submit one claim for every Provider they support.

Provider Claim verification will be considered complete when the vendor has submitted an Approved claim for each category above.